STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00437695, IN00437923, IN00431844, and IN00430036. This visit included a State Residential Licensure Survey. Complaint IN00437695 - No deficiencies related to the allegations are cited. Complaint IN00437923 - Federal/state deficiencies related to the allegations are cited at F580, F684, F689, and F697. Complaint IN00431844 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00430036 - Federal/state deficiencies related to the allegations are cited at F585 and F609. Survey dates: July 10, 11, 12, 15, 16, 17, and 18, 2024 Facility number: 000084 Provider number: 155167 AIM number: 100284600 Census Bed Type: SNF/NF: 123 Residential: 72 Total: 195 Census Payor Type: Medicare: 8 Medicaid: 73 Other: 42	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Westminster Village North Health Center provides anything other than a high quality of care to its residents. Westminster considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Ward	Executive Director	08/13/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 123 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 24, 2024.			
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that			

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	the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review the facility failed to assure residents were treated with dignity and respect for 3 of 9 residents interviewed during Resident Council and 2 of 2 residents reviewed for dignity. (Resident B, P, 52, N, and K) Findings include: 1. The clinical record for Resident N was reviewed on 7/11/24 at 10:04 a.m. The diagnoses included, but were not limited to, unspecified injury of the cervical spinal cord and diabetes. A Significant Change of Status MDS (Minimum Data Set) Assessment, dated 4/8/24, indicated she was cognitively intact. During an interview for Resident Council, on 7/11/24 at 2:30 p.m., Resident N indicated the CNAs (Certified Nurse Aides) would come into her room and turn the call light off, telling her they would be back in a minute, but they never came back. When the staff does not assist with her needs, when her call light was on, she felt "neglected and uncared for". She was to the point where she just "lets it roll". 2. The clinical record for Resident P was reviewed on 7/10/24 at 10:49 p.m. The diagnoses included,	F 0550	This tag was cited due to the residents during the resident council meeting with surveyors expressing that they hadn't been treated with dignity and respect on occasions. These concerns had not been previously shared with staff who assist the Resident Council to conduct their meetings. Resident 52 and other residents of the Resident Council met with the Executive Director and the Associate Executive Director on 7/25/23 and were offered opportunities to share any concerns they had and were assured that any concerns would be addressed by management and the corrective action plans would be shared with the members of the Resident Council. Further information was provided with regard to a system to guide the process of addressing the council's concerns. In order to address this potential concern for any other residents, and to prevent any future	09/08/2024

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	but were not limited to, diabetes and cervical spinal stenosis. A Quarterly MDS Assessment, dated 5/1/24, indicated Resident P was cognitively intact. During an interview, on 7/10/24 at 10:49 a.m., Resident P indicated, a couple of months ago, a nurse had answered her call light. She asked the nurse to assist her with wiping and the nurse asked her "what in the world" did she (Resident P) do at home, and told her that she had never done this for someone before. 3. The clinical record for Resident 52 was reviewed on 7/11/24 at 2:45 p.m. The diagnoses included, but were not limited to, hypertension and stroke. A Quarterly MDS Assessment, dated 4/19/24, indicated she was cognitively intact. During Resident Council meeting, on 7/11/24 at 2:35 p.m., Resident 52 indicated she felt as if the residents in the health center were being treated like "step children". The other parts of the campus had tablecloths on the tables, but the health center did not. 4. The clinical record for Resident B was reviewed on 7/11/24 at 2:50 p.m. The diagnoses included, but were not limited to, diabetes and hypertension. A Quarterly MDS assessment, dated 4/12/24, indicated Resident B was cognitively intact. An interview conducted with Resident B, on 7/11/24 at 9:49 a.m., indicated there were long delays with toileting. He would turn the call light on, and staff would enter his room rather quickly.		occurrences of staff not addressing residents in a dignified manner, the facility will: Provide all residents and families with the updated policy for sharing concerns and grievances **(Attachment A)** Place grievance forms in several key locations throughout the skilled nursing facility with instructions for where to submit them. Provide tools for the Resident Council to share concerns and receive management responses. **(Attachment B & C)** All staff will be educated regarding procedures for appropriately answering call lights, and responding to residents in a way that promotes dignity and demonstrates respect. In order to monitor the effectiveness of these corrections, the Administrator (Associate Executive Director will review each month's Resident Council notes, any concerns shared, and the adequacy of the facility's response. These reviews will remain ongoing. All corrections for this tag will be completed by September 8, 2024	

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	The staff would turn off the call light and state they would return but would never return. He felt like the residents here were treated like the "ugly step children." 5. An interview conducted with Resident K, on 7/10/24 at 11:41 a.m., indicated she had been waiting a long time for incontinent care. She had voiced her concerns to the CNA when she finally came in to provide care. The CNA's response was, "I at least deserve a thirty minute break". A resident rights policy was provided on 7/17/24 at 4:00 p.m. The policy indicated the following, "...The resident has a right to a dignified existence, self-determination, person centered care, communication with and access to persons and services inside and outside the facility, including: treating each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. It is the responsibility of the facility to protect and promote the rights of the resident..." 3.1-3(a) 3.1-3(t)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record	F 0558	This tag was cited due to Resident D having a wheelchair that was not	09/08/2024

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	review, the facility failed to timely provide a resident with a wheelchair that accommodated his height for 1 of 1 resident reviewed for positioning. (Resident D) Findings include: The clinical record for Resident D was reviewed on 7/10/24 at 2:20 p.m. The diagnoses included, but were not limited to, left sided hemiplegia (paralysis of left side) and dependence on wheelchair. He was admitted to the facility on 5/8/24. A care plan, dated 5/9/24, indicated Resident D had a potential for falls related to a history of traumatic brain injury, immobility, non-ambulatory, and abnormal posture due to hemiplegia (unilateral paralysis) affecting his left dominant side. The goal was for him to be free of falls. An Admission MDS (Minimum Data Set) Assessment, dated 5/14/24, indicated Resident D was cognitively intact and used a wheelchair for mobility. On 7/10/24 at 2:20 p.m., Resident D was observed in his room sitting in his wheelchair. He would lean back in the wheelchair with his hips not touching the back of the wheelchair seat. His feet were on the floor with his left ankle turning inward and his left foot flat on the ground. Resident D indicated his wheelchair was too small for him. He was 6 foot 8 inches tall and needed a bigger chair because the one he utilized was very uncomfortable and caused him to hurt all over. He had been using that wheelchair since he admitted to the facility in May. On 7/12/24 at 1:08 p.m., Resident D was observed		the correct size for his function and comfort. The community has purchased a wheelchair for resident D the meets his functional needs as well as his needs for proper positioning and comfort. In order to identify any other residents requiring adaptations to accommodate their specialized needs, the community will, in collaboration with the Therapy Manager, conduct an audit of all residents to assure they have the recommended durable medical equipment. **(Attachment D)** Each resident, as part of their admission assessment, and with any subsequently scheduled assessment reference periods, will have their needs assessed and addressed as appropriate to accommodate any special needs. Interdisciplinary team members will be educated regarding the policy for Accommodation of Needs **(Attachment E**) and the need to address identified needs in the plan of care. Audits to monitor these corrections **(Attachment D),** similar to the audit mentioned above, will be conducted monthly for the next six months in order to assure that the systemic	

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	in the dining room, sitting in his wheelchair. His hips were against the back of the chair and his feet were on the floor. The end of the wheelchair seat was at his mid-thigh. The back of the wheelchair seat was at his mid back, below his shoulder blades. During an interview, on 7/12/24 at 1:31 p.m., QMA (Qualified Medication Aide) 2 indicated Resident D could propel himself in his wheelchair sometimes, but his wheelchair was too small for him. He needed a bigger chair, and the facility was working on getting him one. During an interview, on 7/12/24 at 2:10 p.m., the ADM (Administrator) indicated the facility thought Resident D admitted with a wheelchair from the previous facility. When he arrived, he did not have his own wheelchair. The therapy department had contacted an outside vendor for a specialty wheelchair. The facility had inquired about the possibility of a more expensive chair that was sturdier for long term use, but no quote had been received yet. The ADM had followed up with an outside vendor about Resident D's specialty wheelchair that day, 7/12/24. On 7/12/24 at 2:10 p.m., the ADM provided the Quote Acknowledgement and emails regarding a specialty wheelchair for Resident D. The Quote Acknowledgement was dated, 5/15/24, and included details about the type of chair that was quoted. An email, sent by TM (Therapy Manager) to the outside vendor, was dated 6/10/24, and inquired about follow up on Resident D's custom wheelchair. An email, sent by TM to the outside vendor, was dated 6/19/24, and, again, inquired about follow up about Resident D's specialty wheelchair. An email from the outside vendor to the TM, dated 6/20/24, included the price of		corrections are consistently being followed. All corrections for this tag will be completed by September 8, 2024.	

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	Resident D's specialty wheelchair and cushion. An email, dated 6/24/24, from TM to the outside vendor indicated the ADM had been spoken to about the quote and the ADM had asked if there was a wheelchair available that would be better for Resident D and may last him longer, even if the wheelchair was more expensive up front. An email, dated 6/24/24, from the outside vendor to TM, indicated the chair previously quoted would suffice, but he would contact some additional manufacturers to confirm. During an interview, on 7/15/24 at 10:32 a.m., the TM indicated she had started working on wheelchair positioning with Resident D right after he admitted on 5/8/24. Due to Resident D's height, none of the wheelchairs available at the facility were a good fit for him and she had given Resident D the largest wheelchair available at the facility. The TM had contacted an outside vendor who had previously provided wheelchairs for Resident D when he lived in the community. The TM had received the quotes for Resident D's specialty wheelchair and handed them off to the Administrator on 6/24/24. The facility had to order Resident D's wheelchair because it needed to be a capital expense due to the cost. On 7/15/24 at 12:48 p.m., Resident D was observed in the dining room sitting in his wheelchair at a table. He was leaning to the right in his wheelchair with his left leg extended out. He utilized his wheelchair and using his right hand to feed himself. When he took a bite, he would lean forward to bring his body closer to the spoon. During an interview, on 7/15/24 at 1:40 p.m., Resident D indicated that he had a hard time feeding himself because of his wheelchair. He was unable sit upright at the table because the			

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	wheelchair positioning and felt frustrated because his wheelchair was so uncomfortable and did not fit him correctly. 3.1-3(v)(1)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to			

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	participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on observation, interview, and record review, the facility failed to promptly act on a resident council grievance about tablecloths in the dining room. This had the potential to affect 9 of 123 residents who attend resident council. Findings include: On 7/11/24 at 1:24 p.m., the ADM (Administrator) provided the resident council minutes for April, May, and June 2024. The Resident Council Minutes, dated April 11, 2024, indicated that Resident 52 did not like the tablecloths removed from the dining rooms and the Administrator (ADM) had encouraged her to give the changes of the dining room experience a chance. A Resident Council meeting was held on 7/11/24 at 2:30 p.m. There were 9 residents in attendance. The council indicated the facility had stopped utilizing tablecloths in the health center dining rooms. The assisted living and the independent living dining rooms had tablecloths. The council had expressed concerns about not utilizing tablecloths in resident council meetings. They had not received any follow-up on the grievance of not having tablecloths, other than the "new company" had decided to stop using them. The council felt that they were being treated differently because they were in the health center.	F 0565	This tag was cited due to the facility not recording a response to the Resident Council regarding a concern about why tablecloths were no longer being used in health center dining. The Executive Director and Associate Executive Director along with the Dining Services Manager and the Executive Chef met with the Resident Council, including Resident 52, on 7/25/24 and participated in a robust conversation regarding the changes to our dining program. Residents during this meeting had provided compliments regarding the recent changes and the improved quality of meals in recent weeks. Management assured the Council that it is our goal and our passion to provide a meal service in our skilled nursing facility that has the same quality as the any meal service offered in the other levels of care within our continuum. Although the introduction of our new dining services is rather recent, there are still improvements to make, and our residents will continue to have input into our delivery model.	09/08/2024

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	On 7/17/24 at 8:47 a.m., the dining room was observed in the assisted living part of the facility. There were white tablecloths on the tables. DS (Dietary Staff) 12 indicated that the dining room had tablecloths for each meal served. During an interview, on 7/17/24 at 10:28 a.m., the ADM indicated there were no grievances from resident council for April, May, or June 2024. During an interview, on 7/17/24 at 10:34 a.m., the AD (Activity Director) indicated she assisted with the resident council each month. She had not filled out grievance forms in resident council. She heard the residents' concerns about not having tablecloths in the dining room. The AD had never filled out grievance for the resident council as a general concern. On 7/15/24 at 9:30 a.m., the DON (Director of Nursing) provided the Resident and Family Grievances policy, updated 3/2020, and indicated the following, "...Complaints and concerns expressed by the Resident Council will be promptly addressed by the department manager, and a follow-up response will be provided to the Council..." 3.1-3(l)		Tablecloths had been eliminated for several reasons. Amongst those reasons were, the facility determined that they did not provide any true visual benefit, while the hanging cloths easily interfered with residents' wheelchair arms and could cause frustration while coming to, and moving from, the tables. We purchase new glassware and cloth napkins to improve the look of the pre-set table as an alternative. In the future, such changes will be discussed with the Resident Council prior to implementation. The staff who assist the Resident Council has been provided with a new document to use when the council has concerns to share **(Attachment B & C)** as well as a policy for facilitating the Resident Council meetings which includes the response to shared concerns. All health center managers will receive education regarding this policy Each month the staff assisting the Resident Council will distribute attachment C to the appropriate management staff, including the Associate Executive Director, to prompt them to respond to any concerns shared by the council. Responses will be retained as part of the Resident Council's notes. This monthly audit by the Associate Executive Director will	

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			serve as the audit for monitoring the systemic changes. Corrections for this tag will be completed by September 8, 2024.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate			

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	assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify a resident's representative of a fall event for 1 of 8 residents reviewed for accidents. (Resident F) Findings include: The clinical record for Resident F was reviewed on 7/10/24 at 2:00 p.m. The diagnosis included, but was not limited to, Alzheimer's disease. An Admission Minimum Data Set (MDS) assessment, dated 6/13/24, indicated Resident F was cognitively impaired. A care plan, dated 6/10/24, indicated Resident F had a "potential for falls r/t [related to] deconditioning gait/balance problems, unaware of safety needs. fall in the home, down unknown length of time, seen in ER [emergency room] and	F 0580	This tag was cited due to one resident's family not being made aware of an incident that may or may not have been a fall. Resident F had no previously documented occurrences of purposefully getting onto the floor and the resident's cognition is not intact. Therefore, we will assume that this is a fall. Resident F had no injuries because of this occurrence. The community will correct this for Resident F and any other residents by updating the Falls/Falls Assessment policies **(Attachment F)** to further define incidents that must be assumed to have been falls. The facility's	09/08/2024

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	admit to hospital. Fall in facility impulsive. no injuries..." During a Confidential Interview, they indicated Resident F's Representative was not notified the resident had more than one fall at the facility. A nursing progress note for Resident F, dated 6/21/24, indicated the following, "...Resident was on the floor in Aspen activity room. She said she got up from her wheel chair and sat on the floor. She denied falling. She was taken back to the room." A medical provider note for Resident F, dated 6/21/24, indicated the following, "...She had a fall a few days today [sic] and another one today unwitnessed without injury. Per nursing, patient was found in activity room and reported getting up from her wheelchair to sit on the floor...Patient resting in bed, does not recall fall earlier today. She reports no current pain..." The clinical record did not include notification of Resident F's representative regarding the fall on 6/21/24. A written statement by License Practical Nurse (LPN) 3, dated 7/9/24, indicated, "...I was walking to the unit where I was to work on that day and I saw this lady [Resident F] sitting upright on the floor, I asked if she was okay, she said yes, I asked if she fell, she answered no. I saw the aid walking towards her and I asked the aid if he knew who she was, the aid said yes and that he was going to get her to her room and then for breakfast. I walked pass [sic]. I reported to the NP [Nurse Practitioner] that day how I met the resident and that I went ahead to check her v.s. [vital signs] when I realized she was in the unit I		notification of change policy already requires that falls shall be reported to the doctor and the responsible party. All nurses will be educated regarding the updated policy. When reviewing 24-hour shift report notes, Nursing Administration will monitor for incidents for which the notification of changes policy would apply. These occurrences will be logged on an incident log to be kept to monitor compliance with this plan of correction **(Attachment G)** for the next 4 months, or until 100% compliance has been achieved for 3 consecutive months. All corrections for this tag will be completed by September 8, 2024.	

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	was assigned to work that day. She denied falling and denied having any pain at the time I asked." An interview was conducted with the Director of Nursing (DON) on 7/15/24 at 2:46 p.m. She indicated, on 6/21/24, Resident F did have a fall. The nurse did not consider the resident had fallen after observing Resident F sitting on the floor in the activity's room. During an interview, LPN 3 had stated to the DON she had arrived on the unit and had observed a resident sitting on the floor in the activity's room. She had placed herself on the floor, all the time, so she did not consider it a fall. A notification of resident change in condition policy was provided by the DON on 7/15/24 at 9:30 a.m. It indicated "...Purpose: To establish guidelines for assuring residents, their legal representatives and attending physicians are informed of resident changes in the resident's condition...Standards: 1. A licensed nurse shall immediately inform the resident, consult with the resident's physician and if known, notify the resident's legal representative or an interested family member of: a. An accident involving the resident which there is a potential for or actual injury which could require nursing or medical interventions...9. Resident representative(s) notifications and attempts will be made promptly and documented in the nurse's notes. In the event the licensed nurse is unable to contact the resident's representative, after a reasonable time period, the Director of Nursing will be notified..." This citation relates to Complaint IN00437923. 3.1-5(a)(1)			
F 0585 SS=E	483.10(j)(1)-(4) Grievances			

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Bldg. 00	§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a			

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	written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to			

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	whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to timely address resident grievances, provide dates that grievances were resolved, provide dates that follow up was done with the individual who brought forward the grievance, indicate that grievances were confirmed or not confirmed, and to provide a means for residents to file a grievance anonymously for 7 of 7 grievances reviewed. (Residents N, P, and R) Findings include: 1. The clinical record for Resident N was reviewed on 7/11/24 at 10:04 a.m. The diagnoses included, but were not limited to, unspecified injury of the cervical spinal cord and diabetes. A Significant Change of Status MDS (Minimum Data Set) Assessment, dated 4/8/24, indicated she was cognitively intact.	F 0585	This tag was cited due to grievance forms not being completed fully to ensure that residents received timely feedback regarding any concerns they shared with the facility, and the results of any investigations into their grievances. The facility has updated its policy regarding the receiving, recording, and resolution of residents' grievances **(Attachment A)**. All staff will receive in-service education regarding the updated policy, and the community's requirements to allow for confidential sharing of concerns, and our requirements to investigate and respond appropriately to any concerns	09/08/2024

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	A care plan, last revised on 4/23/24, indicated Resident N had a potential for alteration in mood related to depression, flat affect, reports little interest in doing things, tearful episodes, and critical of staff and routine. The goal was for her to demonstrate an improved mood. The interventions included, but were not limited to, encourage and allow open expression of feelings, initiated 11/8/23, and support my strengths and coping skills, initiated 11/8/23. During an interview, on 7/11/24 at 10:03 a.m., Resident N indicated she expressed concerns to the SSA (Social Services Assistant) about the CNAs (Certified Nursing Assistants) being rude and disrespectful. She did not always receive follow up about her concerns. On 7/12/24 at 2:05 p.m., the SSD (Social Services Director) provided Investigation and Follow-up of Grievance/ Complaint forms for Resident N dated 5/7/24 and 5/21/24. The Follow-up of Grievance/Complaint form, dated 5/7/24, indicated the following, "...Detailed description of complaint: Res [Resident] reported CNA on evening shift 5/6/24 had poor customer service [sic]. Department Involved: Nursing. Corrective Measures: CNA educated on customer service and providing proper care. Manager of Department Involved Must Complete Steps Below: Date of follow-up response: 5/10/24. Date written notification regarding action needed to be offered per policy: [blank]...." There were no documents attached to the Follow-up of Grievance/Complaint form, dated 5/7/24, and the form did not contain information if the grievance had been confirmed or not confirmed.		shared with us. Also included in the in-service will be procedures for referring complaints to administration when a supervisor is not present. Our updated policy **(Attachment A)** will be reviewed with the Resident Council and shared with all residents and families. An Audit will be completed weekly **(Attachment H)** to make certain that grievance forms are available to residents in public areas. Additionally, the Administrator will review the grievance log weekly **(Attachment I)** to make sure all follow-ups are completed and the documentation on the forms/attachments are complete. All corrections for this tag will be completed by September 8, 2024.	

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	The Follow-up of Grievance/ Complaint form, dated 5/21/24, indicated the following, "...Detailed description of complaint: NOC [night] 5/21/24 Res[sic] had complaint related to customer service issues. Department Involved: Nursing. Corrective Measures: Initiated in-service R/T [related to] resident's concern- proper transfers, following CNA assignment sheet R/T transfers. Always use 2 nrsg [nursing] staff for hoyer transfers, ice water pass q [every] shift and prn [as needed]...Manager of Department Involved Must Complete Steps Below: Date of follow-up response: [blank]. Date written notification regarding action needed to be offered per policy: [blank]. Signature of individual responsible for follow-up and notification [Director of Nursing signature present], Signature of Social Service Manager or designee [SSD signature]. Signature of Administrator [ADM signature] ..." The Follow-up of Grievance/Complaint form, dated 5/21/24, did not contain information if the grievance had been confirmed or not confirmed. A copy of a note was attached to the Follow-up of Grievance/Complaint form dated 5/21/24. The note indicated evening shift did not utilize 2 staff when putting Resident N in the mechanical lift. Resident N had asked for water on the NOC (night shift) and had not received the water. Resident N was told not to drink as much so she did not need changed as often. An evening shift CNA had complained about how she had to work a double and being overworked. The NOC shift had been very disruptive when changing Resident N. An education/ training sign-in form was attached to the Follow-up of Grievance/Complaint form dated 5/21/24. The education/ training form was			

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	signed by six staff members and indicated the topics discussed were proper transfers, following the CNA assignment sheets, water and fluids, ice water was to be passed every shift and as needed, and work concerns/complaints are not to be discussed with residents. During an interview, on 7/17/24 at 11:15 a.m., the DON (Director of Nursing) indicated she normally responded to the grievance forms within 48 hours. She did not usually put a date of when she followed up on the concern. She did not offer copies of the grievance forms to the person filing the grievance. Customer service concerns could indicate not addressing a concern properly. The note attached to the Follow-up of Grievance/Complaint form, dated 5/21/24, could have been written by the SSA (Social Service Assistant). The DON did not have any other notes or documentation from the investigation of the grievance from Resident N, dated 5/21/24. During an interview, on 7/17/24 at 2:25 p.m., the SSA indicated she had written the note attached to the Follow-up of Grievance/Complaint form dated 5/21/24. SSA could not recall if Resident N had provided names of the staff members involved. Resident N did not have a history of making false allegations. 2. The clinical record for Resident P was reviewed on 7/10/24 at 10:49 p.m. The diagnoses included, but were not limited to, diabetes and cervical spinal stenosis. A Quarterly MDS Assessment, dated 5/1/24, indicated Resident P was cognitively intact. During an interview, on 7/10/24 at 10:49 a.m., Resident P indicated she had filed grievances			

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	about an evening shift nurse. The nurse had refused to give her insulin correctly and had a disagreement with her and her son about blood pressure medications. The nurse had yelled at her son and was rude. Resident P had requested to speak to a supervisor but was told there was no supervisor. The disagreement about her blood pressure medications had happened on a Friday evening and she had filed the grievance on a Monday. No one had followed up with her regarding a resolution to the grievances. Resident P would prefer that she had another nurse rather than Licensed Practical Nurse (LPN) 11, but there was no one else available. Resident P did not always file grievances about concerns because the nurses could care for her again. On 7/12/24 at 2:05 p.m., the SSD (Social Services Director) provided Investigation and Follow-up of Grievance/ Complaint forms for Resident P dated 5/7/24, 5/24/24, and 6/10/24. The Investigation and Follow-up of Grievance/Complaint form, dated 5/7/24, indicated the following, "...Detailed description of complaint: Res [resident] reported customer service issue w/ [with] nurse evening of 5/6/24. Department Involved: Nursing. Corrective Measures: Verbal one on one education given to nurse in training on customer care and following MD [physician] orders. Manager of Department Involved Must Complete Steps Below: Date of follow-up response: 5/7/24. Date written notification regarding action needed to be offered per policy: [blank]. Signature of individual responsible for follow-up and notification [ADON signature present], Signature of Social Service Manager or designee [SSD signature]. Signature of Administrator [ADM signature] ..."			

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	There were no documents attached to the Follow-up of Grievance/ Complaint form, dated 5/7/24, and did not contain information if the grievance had been confirmed or not confirmed. The Investigation and Follow-up of Grievance/Complaint form, dated 5/24/24, indicated the following, "...Detailed description of complaint: Res [resident] reported issues with insulin timing. Department Involved: Nursing. Corrective Measures: Education and risk were explained to nurse... Nurse reports offering her insulin at different times and resident will refuse but will then sometimes ask for her insulin after the meal. Educated nurse on documentation...Manager of Department Involved Must Complete Steps Below: Date of follow-up response: [blank]. Date written notification regarding action needed to be offered per policy: [blank]. Signature of individual responsible for follow-up and notification [DON signature present], Signature of Social Service Manager or designee [SSD signature]. Signature of Administrator [ADM signature] ..." There were no documents attached to the Follow-up of Grievance/Complaint form, dated 5/24/24, and did not contain information if the grievance had been confirmed or not confirmed. The Investigation and Follow-up of Grievance/ Complaint form, dated 6/10/24, indicated the following, "...Detailed description of complaint: Res [resident] reported issues w/ [with] medication delivery and issues w/ [sic] customer service evening of 6/7/24... Department Involved: Nursing. Corrective Measures: Investigated situation. Per charge nurse she did hold her [Resident P] medication that could lower her BP even more which was the direction of the NP			

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	[nurse practitioner]. Nurse acknowledged the resident was not prescribed the med for BP [blood pressure], but it could cause hypotension...resident wanted to argue the situation and continued to demand the medication, but nurse refused. Nurse reports son came to the facility and when it was explained to him, he voiced understanding. The charge nurse did ask evening supervisor to come to unit and per supervisor... she went to discuss situation. Charge nurse reports the conversation with son was not disruptive to any other residents and was not heated. Manager of Department Involved Must Complete Steps Below: Date of follow-up response: [blank]. Date written notification regarding action needed to be offered per policy: [blank]. Signature of individual responsible for follow-up and notification [DON signature present], Signature of Social Service Manager or designee [SSD signature]. Signature of Administrator [ADM signature] ..." The Follow-up of Grievance/Complaint form, dated 6/10/24, did not contain information if the grievance had been confirmed or not confirmed. A typed note was attached to the Investigation and Follow-up of Grievance/ Complaint form, dated 6/10/24, which indicated that Resident P reported that LPN 11 had brought Resident P her evening medications and checked her vital signs. Resident P's blood pressure was low, and LPN 11 had prepared her medications. Resident P noticed her "orange pills" were not there and told LPN 11 the "3 orange pills" were prescribed for heart rate, not blood pressure. LPN 11 had indicated she was going to mark down that Resident P refused the medication. Resident P had asked to speak to the supervisor and was told by LPN 11 she did not have a supervisor. LPN 11 had come back into			

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	the room a few minutes later to administer medication to the roommate. Resident P had attempted to speak to LPN 11, but LPN 11 had ignored Resident P. Resident P had called her son to come help diffuse the situation. When the son arrived and asked to speak to LPN 11. LPN 11 had loudly replied to the son that "She was being rude to me". Resident P's son had told LPN 11 not to raise her voice at him. LPN 11 and Resident P's son had gone to the hallway and were yelling at each other for several minutes. LPN 11 continued to provide care for Resident P. During an interview, on 7/17/24 at 11:15 a.m., the DON indicated she had investigated the grievance on 6/10/24. DON had spoken with LPN 11 and the evening supervisor about the grievance. She had documented the information about the investigation on the grievance form and signed the form on the back. The DON did not have any other information or documentation about the grievance resolution. During an interview, on 7/17/24 at 2:34 p.m., the SSA indicated she remembered the grievance from 5/7/24 and 6/10/24. The SSA believed the nurse involved in both incidents was LPN 11. The incident, dated 5/7/24, was regarding insulin administration. LPN 11 had offered the insulin sooner than Resident P preferred to take it. Later, Resident P had asked for the insulin and LPN 11 had told her she had already documented it as refused. The incident, dated 6/10/24, was about blood pressure medications. Resident P and LPN 3 had a disagreement about blood pressure medications. Resident P had become upset with LPN 11 over her blood pressure medication. Resident P had called her son about the disagreement. When the son came in, Resident P reported that LPN 11 and her son had yelled at			

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each other in the hallway. The SSA had offered to look into Resident P administering her own medication or to look into an assisted living environment for her. Resident P did not want to pursue either of those options.

During an interview, on 7/17/24 at 2:50 p.m., the ADON (Assistant Director of Nursing) indicated she had investigated and followed up on Resident P's grievance, dated 5/7/24. The ADON found out that Resident P had not wanted to take insulin when it was offered from LPN 11. Resident P requested later that LPN 11 administer the insulin that had been offered earlier in the shift, and LPN 11 had told Resident P that she could not receive the insulin because the insulin was documented as refused. LPN 11 was new to the facility at the time and the ADON had educated LPN 11 on getting a one-time order from the physician to give the insulin if that scenario happened again. The grievance form had been filled out by the SSA. The SSA had indicated customer service issue on the grievance form but had come to the ADON and verbally explained the grievance in greater detail.

3. The clinical record for Resident R was reviewed on 7/12/14 at 11:29 a.m. The diagnoses included, but were not limited to, adult failure to thrive and severe dementia with psychotic disturbance.

On 7/12/24 at 2:05 p.m., the SSD (Social Services Director) provided two Investigation and Follow-up of Grievance/Complaint forms for Resident R dated 3/4/24.

The first Investigation and Follow-up of Grievance/Complaint form, dated 3/4/24, indicated the following, "...Detailed description of complaint: Res [resident] family concerned of

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	nursing communication, in regards to res [sic] care and res [sic] being NPO [nothing by mouth]. Department Involved: Nursing. Corrective Measures: Family has posted signs r/t [related to] NPO. CNA Assignment sheet, care plan, and orders updated. Manager of Department Involved Must Complete Steps Below: Date of follow-up response: [blank]. Date written notification regarding action needed to be offered per policy: [blank]. Signature of individual responsible for follow-up and notification [DON signature present], Signature of Social Service Manager or designee [SSD signature]. Signature of Administrator [ADM signature] ..." The second Investigation and Follow-up of Grievance/Complaint form, dated 3/4/24, indicated the following, "...Detailed description of complaint: Residents family has complaints in regards to requesting x-ray for res [sic] back due to res. complaining to family of back pain. Department Involved: Nursing. Corrective Measures: upon investigation with nursing staff resident did not c/o [complaints of] [sic] pain to them. She was transferring and ambulating without complaints. No request for x-rays per charge nurse. Manager of Department Involved Must Complete Steps Below: Date of follow-up response: [blank]. Date written notification regarding action needed to be offered per policy: [blank]. Signature of individual responsible for follow-up and notification [DON signature present], Signature of Social Service Manager or designee [SSD signature]. Signature of Administrator [ADM signature] ..." The Follow-up of Grievance/Complaint forms, dated 3/4/24, did not contain information if the grievances had been confirmed or not confirmed			

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	On 7/16/24 at 2:01 p.m., the bulletin board on the Willow unit was observed. The bulletin board had a sign which indicated Grievance Officer Information, which indicated the Grievance Officer was the SSD, and to file a grievance in person or anonymously, to contact the SSD. On 7/16/24 at 2:15 p.m., the Willow unit was observed with RN (Registered Nurse) 7. RN 7 indicated there were grievance forms behind the nurses' station, but not out on the unit. On 7/17/24 at 10:15 a.m., the Heatherwood unit was observed with CNA 10. CNA 10 indicated that grievance forms were available behind the nurses' desk in a drawer. There were no grievance forms available on the unit. On 7/17/24 at 10:17 a.m., the Juniper unit was observed with RN 5. RN 5 indicated that there were no grievance forms available in the common areas of the unit. On 7/17/24 at 10:09 a.m., the Cedar Unit was observed with SSA 3. SSA 3 indicated that there were no grievance forms available without asking staff. During an interview, on 7/17/24 at 10:34 a.m., the SSD indicated her role in the grievance process is to track and make sure the managers are addressing the grievances and completing the forms. She provided information about grievances to the Quality Assurance committee. The individual managers of the departments are responsible for addressing the concerns. If a resident or family would like to file a grievance anonymously, they could use a piece of paper and put it under my door. There are no grievance forms available on the units without asking for			

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	one. During an interview, on 7/17/24 at 11:15 a.m., the DON indicated she normally responded to the grievance forms within 48 hours. She did not usually put a date of when she followed up on the concern. She did not offer copies of the grievance forms to the person filing the grievance. Customer service concerns could mean not addressing a concern properly. On 7/15/24 at 9:30 a.m., the DON provided a copy of the Resident and Family Grievance Policy, last updated 3/2020, which indicated the following, "...Policy: It is the policy of [name of facility] that residents may voice complaints and grievances with respect to treatment and care that is or fails to be furnished, and recommend changes in policy and services without fear of discrimination, reprisal or interference... The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state federal agencies as necessary in light of specific allegations. Concern/ Suggestions forms are available at the nurse's station, at the customer service in the Social Services offices and upon request. Staff members must report the concern/ suggestion and complete a concern/ suggestion form. Residents or family members may complete the form personally... If the complaint is not resolved within five [5] days, the Director of Health Center Operations, Executive Director or a Designee determine the reason for the delay...The findings of each investigation and actions taken in response to those findings will be reported in			

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	writing the individual[s] who registered the original complaint or concern upon request. Ensuring that all written grievance decisions include the date the grievance was received a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern[s], a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued... The individual voicing the complaint or concern will receive follow-up information...Resolution conference reports will be signed by all involved parties..." This citation relates to Complaint IN00430036. 3.1-7(a)(1) 3.1-7(a)(2) 3.1-7(a)(3) 3.1-7(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the			

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	allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse or neglect were timely reported to IDOH (Indiana Department of Health) for 1 of 2 residents investigated for dignity. (Resident N) Findings include: The clinical record for Resident N was reviewed on 7/11/24 at 10:04 a.m. The diagnoses included, but were not limited to, unspecified injury of the cervical spinal cord and diabetes. A Significant Change of Status MDS (Minimum Data Set) Assessment, dated 4/8/24, indicated she was cognitively intact. On 7/12/24 at 2:05 p.m., the SSD (Social Services Director) provided Investigation and Follow-up of Grievance/ Complaint forms for Resident N dated 5/21/24.	F 0609	This tag was cited due to an allegation that was investigated and addressed not being reported to the State Agency. It should be noted that Westminster Village has a well-established history of reporting unusual occurrences, including allegations, to the Indiana Department of Health per the State's policy. The lack of report in this circumstance appears to have been an oversight. We have updated our complaint/grievance form **(Attachment J)** to include an evaluation of whether the resident's concern constitutes abuse/neglect or otherwise would be considered to be a reportable/unusual occurrence, and the date it was reported and by whom. The facility simply	09/08/2024

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	The Follow-up of Grievance/ Complaint form, dated 5/21/24, indicated the following, "...Detailed description of complaint: NOC [night] 5/21/24 Res [resident] had complaint related to customer service issues. Department Involved: Nursing. Corrective Measures: Initiated in-service R/T [related to] resident's concern-proper transfers, following CNA [certified nurse aide] assignment sheet R/T [sic] transfers. Always use 2 nrsg [nursing] staff for hoyer transfers, ice water pass q [every] shift and prn [as needed]...Manager of Department Involved Must Complete Steps Below: Date of follow-up response: [blank]. Date written notification regarding action needed to be offered per policy: [blank]. Signature of individual responsible for follow-up and notification [Director of Nursing signature present], Signature of Social Service Manager or designee [SSD signature]. Signature of Administrator [ADM signature] ..." A copy of a note was attached to the Follow-up of Grievance/ Complaint form dated 5/21/24. The note indicated Resident N had asked for ice water on the NOC (night shift) and had not received the water. A CNA had told Resident N not to drink as much so she did not need "changed" as often. During an interview, on 7/17/24 at 11:15 a.m., the DON (Director of Nursing) indicated that she would consider a CNA telling a resident not to drink so much so that they did not need changed as often to be abusive. The DON did not have any other notes or documentation from the investigation of the grievance, dated 5/21/24, from Resident N. The nursing staff had denied the allegation. The DON was unsure if the Administrator had reported the incident to IDOH or initiated an investigation.		follows the Indiana Department of Health's policy for reporting, and this policy has been reviewed with facility management. Facility managers have also been familiarized with the new form. This form will be audited weekly during the Administrator's audit of grievance forms as outlined in the plan of correction for F585. All corrections for this tag will be completed by September 8, 2024.	

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	During an interview, on 7/17/24 at 2:25 p.m., the SSA (Social Service Assistant) indicated she had written the note attached to the Follow-up of Grievance/Complaint form dated 5/21/24. SSA could not recall if Resident N had provided names of the staff members involved. Resident N did not have a history of making false allegations. During an interview, on 7/18/24 at 12:02 p.m., the ADM (Administrator) indicated the facility did not report the grievance, dated 5/21/24, by Resident N to IDOH. There was no report and/or file for that incident. On 7/10/24 at 12:21 p.m., the ADM provided the Abuse Policy, last updated 11/15/17, which indicated the following, " ...It is the policy of [name of facility] to protect residents from all abusive acts and to comply with state and federal laws and regulations for reporting suspected or actual acts ... 15. All reports of suspected or known abuse shall be reported immediately or within 24 hours via telephone to the Indiana /state Department of Health....Initial reports will include names of residents, staff or others involved, brief description of the alleged or actual occurrence, description of investigative and protective actions taken ...Zero Tolerance Campaign ... Not assisting a resident with specific needs when a resident clearly cannot help themselves ...Making a resident feel bad when asking for help because you feel overworked or tired ...These are true examples of abuse... Abuse is anything that could potentially harm a resident ...Also, Neglect is abuse..." This citation relates to Complaint IN00430036. 3.1-28(c)			

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure vital signs were obtained prior to administering a medication with parameters to hold for blood pressure measurements (Resident 32), ensure a urinalysis was followed up with and obtained per physician/nurse practitioner (NP) recommendations (Resident 80) for 2 of 5 residents reviewed for unnecessary medications, and failed to ensure residents attended a neurology appointment (Resident N and Resident F) for 1 of 1 resident reviewed for rehabilitation services and 1 of 8 residents reviewed for falls. Findings include: 1. The clinical record for Resident 32 was reviewed on 7/17/24 at 2:49 p.m. The diagnoses included, but were not limited to, chronic kidney disease, congestive heart failure, and diabetes mellitus. A Significant Change Minimum Data Set (MDS) assessment, dated 5/23/24, indicated Resident 32 received diuretic medication. A care plan for congestive heart failure, revised 6/16/24, indicated the intervention to give cardiac medications as ordered.	F 0684	This tag was cited due to: a A missed blood pressure for resident 32 b A missed urinalysis recommendation for resident 80 c Missed appointments related to transportation scheduling conflicts for residents F and N To prevent similar occurrences for residents 32, 80, F and N, as well as, any other residents, the facility will provide in-service education to nurses to provide reminders regarding: Taking and recording vital signs for any medications that might have specific order parameters for holding or otherwise modifying the dose based on measured values. The facility's system for tracking and following up on MD and NP orders/recommendations Monitoring and following appointment schedules. The facility's procedures for monitoring these items are being reviewed.	09/08/2024

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	A care plan for diuretic therapy, revised 4/18/24, indicated the intervention to monitor vital signs as ordered. A physician order, dated 7/2/24, was noted for torsemide (diuretic medication) 10 milligrams daily related to congestive heart failure. The order indicated to hold the medication if systolic blood pressure (the first number that measures the pressure your blood is pushing against your artery walls when the heart beats) was less than 100. The electronic medication administration record (EMAR), dated July of 2024, did not indicate a blood pressure was obtained prior to administration of torsemide 10 milligrams from 7/2/24 through 7/17/24. The vitals documented for Resident 32 indicated a blood pressure was obtained daily but in the evening time, on 7/2/24, and 7/4/24 through 7/16/24. A policy titled "Blood Pressure, Measuring", revised September 2010, was provided by the Director of Nursing (DON) on 7/17/24 at 4:50 p.m. The policy indicated the following, " ...1. Review the resident's care plan to assess for any special needs of the resident ...." 2. The clinical record for Resident 80 was reviewed on 7/17/24 at 2:03 p.m. The diagnoses included, but were not limited to, dementia, depression, anxiety disorder, and chronic kidney disease. An incontinence care plan, revised 8/21/23, indicated to monitor for signs and symptoms of a urinary tract infection (UTI) such as pain, burning,		The facility will monitor compliance with these policies by auditing **(Attachments K, L, and M)** the following: All residents with measured vitals or other values required before administering a medication. This will be conducted weekly over the next month, and monthly thereafter until 100% compliance has been achieved over 90 days. All residents with labs, x-rays, or referrals made by the NP or MD to verify recommendations were followed. This will be conducted weekly over the next month, and monthly thereafter until 100% compliance has been achieved over 90 days. The transportation schedules monthly to verify that all scheduled appointments were attended by residents unless there were factors requiring the cancellation or rescheduling of the appointment due to factors outside of the facility's control. All corrections for this tag will be completed by September 8, 2024.	

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	altered mental status, change in behavior, and/or change in eating patterns. A nurse practitioner (NP) note, dated 11/14/23, indicated Resident 80 was being evaluated due to dementia with behaviors, depression, loose stools, and anxiety. Resident 80 was refusing care and combative with staff. A "UA [urinalysis] ordered today". Physician orders, dated 11/13/23, 11/15/23, and 11/16/23, indicated a urinalysis with culture and sensitivity (test that checks for bacteria in the urine that could be causing an infection in the urinary tract) to be obtained. A progress note, dated 11/15/23, indicated a urine specimen was unable to be collected after several attempts. A progress note, dated 11/17/23, indicated a urine specimen was unable to be collected due to resident being aggressive and agitated. A NP note, dated 11/30/23, indicated the following, " ...being evaluated acutely today for dementia with behaviors, loose stools, and anxiety. Nursing staff reports that patient has been refusing care and was combative with staff ...Has dementia and staff reports she does sundown [refers to a state of confusion that occurs in the late afternoon and lasts into the night. Sundowning can cause various behaviors, such as confusion, anxiety, aggression or ignoring directions. Sundowning also can lead to pacing or wandering]. UA ordered today ...." There were no laboratory results regarding a urinalysis, dated November 2023, for Resident 80 in the hard chart.			

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	An interview conducted with the Assistant Director of Nursing (ADON), on 7/17/24 at 4:58 p.m., indicated there were no urinalysis results in the hard chart for Resident 80. An interview conducted with the ADON, on 7/18/24 at 10:30 a.m., indicated that there was no urinalysis results for Resident 80 in November of 2023. She indicated Resident 80 was combative and did not allow staff to collect the urine sample for the urinalysis. There were no progress notes to indicate follow up regarding the urinalysis for Resident 80 that was not collected due to agitation and the NP note, dated 11/30/23, indicating a urinalysis order. A policy titled "Obtaining Lab Policy", undated, was provided by the DON on 7/17/24 at 4:50 p.m. The policy indicated the following, " ...Culture and sensitivity lab results are monitored as part of the facility's antibiotic stewardship program ...1. Laboratory testing, including culture and sensitivity testing, shall be in accordance with physician/practitioner orders and current standards of practice ...." 3. The clinical record for Resident F was reviewed on 7/10/24 at 2:00 p.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease. The resident was admitted on 6/6/24. An Admission MDS assessment, dated 6/13/24, indicated Resident F was cognitively impaired. A hospital discharge summary, dated 6/6/24, indicated Resident F was referred for a neurology consultation. The summary provided the neurology contact information.			

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	A care plan meeting summary for Resident F, dated 6/10/24, indicated the resident's representatives had requested a neurology consultation, since it had been discussed in the hospital prior to discharge. The resident's clinical record did not include documentation date and time of the neurology consultation nor arrangement of transportation to the appointment. During a Confidential Interview, they indicated Resident F was to be seen by neurology, and the facility had not made arrangements to be seen nor transportation. The facility staff had told Resident F's Representative 2 the neurology appointment was scheduled for 6/25/24. Resident F's Representative 2 had gone to the neurology appointment, on 6/25/24, expecting to meet Resident F there. On arrival, the neurology office staff had indicated Resident F did not have an appointment that day. Resident F was also not present in the office. Resident F's Representative 2 had contacted the facility staff that day prior to the appointment to confirm the resident had an appointment and transportation was made. Registered Nurse (RN) 25 assured her the appointment was set and transportation was made. One of the conversations via phone with RN 25, RN 25 had indicated Resident F had already been transported to the appointment. Resident F's Representative 2 was worried Resident F was missing. She had not arrived at the appointment. She had to notify RN 25 the resident did not have a scheduled appointment. Finally, Resident F's Representative 2 had located Resident F. She was in her pajamas in the facility. An email written by RN 25, dated 6/25/24, indicated the following, "The appointment was set			

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	on June 10th. I called the office today to see what happened once it was brought to my attention that she wasn't scheduled. The office said it was a mistake on their end because they never completed the full scheduling...I did speak to the [Resident F's Representative] on 3 different occasions today and ensured her everything was set because I was under the impression it was..." A written statement by RN 25, not dated, indicated the following, "On June 10th , Resident [F] had a care plan meeting where I attended. [Resident F's Representatives 1 and 2] voiced concerns of wanting a neurology consult due to her newly diagnosed of dementia. I called neurology [office] that day. Spoke with someone in the office who told me they scheduled her for Tuesday, June 25th @ 2 pm [at 2:00 p.m.]...On June 25th, [Resident F' Representative 2] called a few times making sure we had the proper paperwork to send. I told her everything was ready. [Resident F's Representative] called a 4th time but I missed the call as I wasn't sitting at the nurse's station. She then called [Resident F's] cell phone. The [Certified Nursing Assistant] CNA brought me a cell phone stating someone wanted to talk to me never told me who phone it was [sic]. I answered on speaker phone saying this is [RN 25]... [Resident F's Representative] 2 asked me is [Resident F] there with you. I said I'm not sure, I'm on another side of Aspen. The other nurse I was giving report to said he will go to her room to check. She kept asking me is [Resident F] there with you. I said one of my co-workers is going to check. She said, you are talking to me on [Resident F]'s cell phone. I said, oh, I didn't know who phone I was on but if this [Resident F's] phone I'm going to assume she's here then. I proceeded to just figure out what happened and explained to [Resident F's Representative] 2 we			

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	would figure out what happened and notify her." An interview was conducted with the DON on 7/15/24 at 3:30 p.m. She indicated the staff document outside scheduled appointments on a calendar with appointment and transportation information. An interview was conducted with the Administrator (ADM) on 7/16/24 at 8:50 a.m. She indicated there had been an error in scheduling the neurology consultation for Resident F. The facility staff had contacted the neurology office and scheduled the appointment for 6/25/24. The neurology staff had made an error in their system which caused the appointment to not be scheduled. Transportation did not come that day to transport the resident to the appointment. An interview was conducted with RN 25 on 7/16/24 at 9:30 a.m. She indicated she did schedule transportation to transport Resident F to her neurology appointment. She believed she canceled it. 4. The clinical record for Resident N was reviewed on 7/11/24 at 10:04 a.m. The diagnoses included, but were not limited to, unspecified injury of the cervical spinal cord and diabetes. A Significant Change of Status MDS Assessment, dated 4/8/24, indicated she was cognitively intact. A Health Status Note, dated 4/9/2024 at 2:33p.m., indicated Resident N had missed a follow-up appointment with neurosurgery due to transportation issues. A Progress note, dated 6/11/2024 at 1:35 p.m., indicated that Resident N's neurosurgery follow up appointment had been rescheduled and			

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	transportation had been scheduled. Resident N had been notified of the appointment date and time and the calendar had been updated. During an interview, on 7/11/24 at 2:05 p.m., Resident N indicated that she had missed several neurology appointments. The last one she missed was, June 2024, and she had missed the appointment because the facility staff did not have her ready in time. During an interview, on 7/17/24 at 11:15 a.m., the DON indicated Resident N had missed a neurology appointment on 6/10/24 due to the nurse not checking the schedule. The transportation driver had been at the building to transport Resident N to the appointment but would not wait for her to get ready. On 7/18/24 at 9:30 a.m., the DON provided the current Transportation Services Policy which indicated the following, "...Duties and Obligations of the Facility to arrange transportation to/from medical appointments...Nursing staff, or designee, to make arrangements with the transportation vendor to supply ambulance and/or wheelchair transportation in the even [sic] that family cannot transport...Nursing staff to ensure resident is ready for appointment..." This citation relates to Complaint IN00437923. 3.1-37(a) 3.1-37(b)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure incident reports were completed after each fall event, post fall assessments were completed on every shift (morning, evening, and night) for 72 hours, and fall interventions were in place for 5 of 8 residents reviewed for accidents. (Residents E, C, F, M, and D) Findings include: 1. The clinical record for Resident E was reviewed on 7/12/24 at 10:30 a.m. The diagnoses included, but was not limited to, dementia and a displaced comminuted (broken in at least two places) fracture of the right femur. A Quarterly Minimum Data Set (MDS) assessment, dated 2/4/24, indicated Resident E required substantial/maximal assistance with transfers to and from bed/chair, toileting, and moving from a sit to stand/stand to sit position. Resident E was not cognitively intact. 1a. A nursing note, dated 12/24/23 at 12:23 p.m., indicated Resident E's Certified Nursing Assistant (CNA) had observed Resident E walking back from her bathroom and witnessed her fall in the bedroom. Resident E complained of a headache and left leg pain. No further progress notes from that day indicated what/if any new interventions were put in place to prevent another fall.	F 0689	This tag was cited due to 72 hour post fall assessment not being completed, fall investigation reports not being complete, new interventions not recorded Falls that have occurred in the last 30 days will be reviewed and the interdisciplinary team (IDT) will revise the plans of care to address the presumed root causes for each fall. **(Attachment G)** The facility has developed a new system for addressing falls. Each business day the IDT will meet to review any falls that have occurred since the last IDT meeting. Team members will agree on the root causes of falls, record them in the medical record, recommend an intervention to prevent further falls, record them on the plan of care and assignment sheets, communicate them to staff, and pursue any orders relevant to the interventions (i.e. durable medical equipment, therapy orders, medical referrals, etc…). Additionally, Nurses will receive education regarding the facility's policy **(Attachment F)** for	09/08/2024

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	Resident E's post fall assessment, dated 12/24/23 at 12:00 p.m., indicated the post fall assessments were to be completed every shift for three days post fall event. Resident E only had one other post fall assessment completed regarding the fall, on 12/24/23, and it was dated 12/24/23 at 10:06 p.m. 1b. A nursing note, dated 1/28/24 at 5:52 p.m., indicated Resident E was sitting in the dayroom with other residents when she got up from her chair to follow another resident, and got tangled in an oxygen line, tripped, and fell onto her left side. The note stated, initially, Resident E did not complain of pain but then complained of right knee pain at a 3 or 4 out of 10 on a numeric pain scale. Her right knee had a small area that "looked like a rug burn" on her knee. No x-ray was ordered at the time. No further progress notes from that day indicated what/if any new interventions were put in place to prevent another fall. A fall incident report, dated 1/28/24 at 5:42 p.m., indicated the immediate action was to obtain vital signs and assist resident off the floor; injuries observed at time of incident were none; level of pain was 3 out of 10; the predisposing factor was "other"; nothing was check marked for predisposing environmental factors; predisposing psychological factors were: impaired memory, confusion, and "other" with no description; and predisposing situation factors were: active exit seeker, ambulating without assistance and wandering. The incident report did not include if any new interventions were put into place to prevent Resident E from further falls nor was the incident report part of Resident E's clinical record. At the bottom of the incident report it indicated,		completion of fall follow-up assessments, neurological checks (when applicable), and the need for immediate intervention. Audits **(Attachment G)** will be conducted to confirm that 72-hour fall follow-up assessments are completed per facility policy that new interventions are listed for each fall on the plan of care, and that root cause analysis is recorded in the medical record. These audits will be conducted weekly until the facility demonstrates 100% compliance over 90 days. All corrections for this tag will be completed by September 8, 2024.	

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	the report was "Not part of the Medical Record". An IDT note, dated 1/29/24, indicated Resident E ambulates and tripped over another resident's oxygen tubing in the activity common area. "Nursing staff and activities directed to be more mindful of environment, although resident with oxygen does frequently get up and move about." Resident E's post fall assessments (every shift for three days) were completed on: 1/29/24 at 4:57 a.m., 1/29/24 at 8:46 p.m., and 1/30/24 at 6:12 a.m. The post fall assessments for Resident E's fall, on 1/28/24, were not completed every shift for three days. Resident E's fall care plan, last revised on 5/20/22, included but not limited to, a fall intervention, dated 9/2/19, to ensure that floors are free of clutter and spills. Resident E's care plan was not updated with a new intervention for falls following the fall on 1/28/24. 1c. A nursing note, dated 2/10/24 at 7:35 p.m., indicated Resident E had an unwitnessed fall at about 5:55 p.m. Resident E had attempted to throw out some food her family had brought in for her. Resident E denied pain and was assisted back into her chair. The nursing note made no mention of starting neurological assessments on Resident E following an unwitnessed fall. No further nursing notes from that day indicated what/if any new interventions were placed to prevent another fall. The fall incident report, dated 2/10/24 at 6:42 p.m., indicated Resident E fell out of her wheelchair and onto her knees while trying to throw away food. Immediate actions taken were: vital signs taken, body inspection, no noted swelling or bruises,			

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	and resident denied having any pain. No injuries were noted at the time and the predisposing factor was impaired memory. The fall incident report did not indicate neurological assessments were to be conducted following an unwitnessed fall. An IDT note, dated 2/12/24, indicated Resident E had poor safety awareness and lost her balance while trying to throw away food. Resident E was in her wheelchair at the time of the fall. The IDT note indicated the following, "Will continue with close observation". Resident E's post fall assessments were completed on: 2/10/24 at 7:54 p.m. and 8:09 p.m., 2/11/24 at 4:41 a.m., 2/12/24 at 6:28 a.m., and 2/12/24 at 6:26 p.m. The post fall assessments for Resident E's fall, on 2/10/24, were not completed every shift for three days. Resident E's fall care plan, last revised on 5/1/2022, included, but were not limited to, a fall intervention, dated 9/2/19, to ensure personal items were within reach and anti-roll back to wheelchair to reduce falls, dated 3/3/20. Resident E's care plan was not updated with a new intervention following the fall event on 2/10/24. 1d. A nursing note, dated 2/14/24 at 2:35 p.m., indicated Resident E was sitting in a chair by the activity room door and, when the nurse returned to the area approximately five minutes later, Resident E was found sitting on the floor. Her wheelchair was still next to the activity room door and Resident E was leaning on the wall next to the dining room door, which was approximately six feet away from her wheelchair. She was tapping on the door to the dining room and was unable to explain what had occurred but denied pain. Resident E was assisted back into the wheelchair			

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	and assessed. No injuries were noted, and neurological checks were initiated per protocol. No further nursing notes from that day indicated what/if any new interventions were placed to prevent another fall. A fall incident report, dated 2/14/24 at 2:30 p.m., indicated Resident E was noted to be sitting on the floor, with her back against the wall and tapping on the dining room door which was approximately six feet from where her wheelchair was located. Immediate actions taken were: assisted resident up off the floor back into her wheelchair and was placed next to a CNA, she was assessed for injuries and vital signs, and neurological checks were initiated. A predisposing factor was crowding. The post fall assessments for Resident E were completed on 2/14/24 at 2:45 p.m. and 10:57 p.m., 2/15/24 at 4:09 a.m., 2/16/24 at 6:04 a.m. and 9:33 p.m. The post fall assessments for Resident E's fall, on 2/14/24, were not completed every shift for three days. An IDT note, dated 2/15/24, indicated Resident E attempted self-ambulation from her wheelchair. The IDT note indicated the following, "Will continue with close observation and activities of choice...encouraged to spend time in the activity room for closer observation, but will wander off..." Resident E's fall care plan, last revised on 5/1/2022, included, but were not limited to, a fall intervention, dated 9/2/19, to ensure personal items were within reach and anti-roll back to wheelchair to reduce falls, dated 3/3/20; "encourage resident to attend activities", initiated on 2/5/20, and "Resident transfers and attempts self-ambulation". Resident E's care plan was not			

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	updated with a new intervention following the fall event on 2/14/24. 1e. A nursing note, dated 3/19/24 at 5:00 p.m., indicated Resident E was up walking around in her room when staff attempted to redirect her towards her wheelchair. She became aggressive towards the staff and fell from her waist down onto her left side. No injuries were noted, and staff called Resident E's daughter to see if she would come to the facility to be with the resident. A nursing note, dated 3/19/24 at 7:15 p.m., indicated Resident E was up walking around in her room when a CNA asked her to use her wheelchair. Resident E became aggressive with staff members and was cursing at them when she fell on her left side from her waist down. Resident E's daughter was called to come to the facility. No further nursing notes from that day indicated what/if any new interventions were placed to prevent another fall. A fall incident report, dated 3/19/24 at 8:31 p.m., indicated Resident E had been up walking around her room without the use of her wheelchair and when staff asked her to use her wheelchair, she became aggressive with staff when she fell onto her left side. Resident indicated the two staff members were telling her what to do. Immediate actions taken included assisting the resident off the floor, called her daughter, and attempted to get vital signs but the resident was not allowing them by moving her hands around. No injuries were noted, predisposing environmental factors were poor lighting, and predisposing situation factors was ambulating without assistance. An IDT note, dated 3/20/24, indicated Resident E was upset with staff for attempting to redirect her			

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	to sit in her wheelchair for safety when she fell. The note indicated the following, "Behaviors/mood will be observed for any necessary interventions. Staff is aware to give her space when anxious...Poor safety awareness due to impaired cognition...." Resident E's fall care plan, last revised on 5/1/2022, included, but was not limited to, interventions, dated 9/2/2019, were to ensure that resident wears non-skid footwear when ambulating or propelling the wheelchair and maintain adequate lighting with room and hallways. Resident E's care plan was not updated with new interventions following the fall event on 3/19/24. 1f. A nursing note, dated 3/20/24 at 5:29 p.m., indicated Resident E was sitting in the common area with staff and peers present, when a staff member had got up to assist another resident, and Resident E got up from her wheelchair at the same time then walked from the dining room door to the activity room door and fell into the activity room. Resident E was not able to explain what had occurred but did report pain in her knee. The note indicated neurological checks were initiated per protocol and range of motion was maintained. A fall incident report, dated 3/20/24 at 5:15 p.m., indicated Resident E was sitting in common area when she got up and walked toward the activity room and fell in the doorway of the activity room landing on her side. Immediate actions taken were: vital signs taken, resident assessed, pain medication given, and neurological checks were initiated per protocol. Predisposing physiological factors were confusion, gait imbalance, and impaired memory. Predisposing situation factors were ambulating without assistance.			

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	A nursing note, dated 3/20/24 at 11:22 p.m., indicated, Resident E, while resting in her bed, complained of knee pain rating a 7 out of 10 on the numeric scale. Her right knee was noted to be swollen, tender to touch, and would only move her leg when necessary. The note indicated the knee did not look out of place and no "signs of broken bones". No further nursing notes from that day indicated what/if any new interventions were placed to prevent another fall. An IDT note, dated 3/21/24, indicated the following, "continue with close observations and keeping her busy as possible with activities. Resident is impulsive and [sic, has] poor safety awareness." A nursing note, dated 3/21/24 at 6:40 a.m., indicated Resident E fell the previous evening and called Resident E's physician. An order for a portable x-ray was received for the right knee which was swollen and painful. A nursing note, dated 3/21/24 at 4:13 p.m., indicated Resident E had a displaced comminuted fracture of the distal femur. The nurse practitioner and family were notified and would be in to see the resident that day. A nursing note, dated 3/21/24 at 5:15 p.m., indicated Resident E's family requested she be sent to the local emergency department related to the fracture of the distal femur. Resident E was later sent to the local emergency room and did not return to the facility until 3/28/24. No further progress notes, from 3/21/24 until 4/1/24, indicated what/if any new interventions were put in place to prevent another fall.			

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	A nursing note, dated 4/1/24 at 7:47 p.m., indicated Resident E remained "on increased monitoring for recent hospitalization for right distal femur fracture secondary to a fall. Dressings to Right femur and Right knee removed this day revealing 49 staples to R [sic, right] femur and 4 staples noted to R [sic] knee..." An interview conducted with Resident E's family member, on 7/15/24 at 12:28 p.m., indicated Resident E's repeated falls were concerning. She indicated she could possibly understand the first fall, on the day before Christmas, because she was in her room ,but when her mom was still falling in the common area where more supervision was supposed to occur then they were concerned. Resident E's daughter indicated she was told the facility was going to have her mom spend more time in the common area with peers so more staff would be able to watch her, but that didn't seem to prevent her from falling. Resident E's daughter further indicated they themselves requested for Resident E to be sent to the hospital as the facility was going to treat her fracture medically. She indicated not only was Resident E sent to surgery to repair the fractures, but she also had a brain bleed. 2. The clinical record for Resident C was reviewed on 7/16/24 at 1:49 p.m. The diagnoses included, but was not limited to, congestive heart failure (CHF), dementia with anxiety and mood disturbance, and anxiety disorder. A Quarterly MDS assessment, dated 2/16/24, indicated she had moderate cognitive impairment and required supervision/touching assistance with toileting, personal hygiene, transferring on/off toilet, moving from a lying to sitting position/sitting to lying position, transferring from			

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	chair to bed/bed to chair, and was independent to walk 10 feet. A Significant Change MDS assessment, dated 4/19/24, indicated her cognitive status declined and was totally dependent on assistance for toileting, personal hygiene, transferring on/off toilet, moving from a lying to sitting position/sitting to lying position, transferring from chair to bed/bed to chair and walking 10 feet was not attempted due to safety concerns. A physician's order, dated 4/12/24, indicated Resident C was to be admitted to hospice. 2a. A nursing note, dated 4/2/24 at 8:30 a.m., indicated Resident C continued to cry out that morning, asking her roommate to call for help, and yelling for her roommate. Resident C also attempted to get out of her recliner several times while the writer of the note attempted to put her back in chair several times, and explained for her to call for staff assistance, and not her roommate as the roommate was being disturbed. Resident C indicated, she understood, but continued to call for roommate. Resident C attempted to get out of chair and attempted to fall onto the ground, when the writer had to hold resident's arm to prevent and break the fall. Resident C was placed in her wheelchair and taken to the dining room for breakfast. An IDT note for the fall event, dated 4/2/24, was not located by DON. 2b. On 4/4/24 at 6:45 p.m., a nursing note indicated facility staff was alerted that Resident C had fallen out of the recliner and was in front of the recliner lying flat on her back and had pulled her oxygen off. Resident C was assessed, and a			

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	neurological assessment was within normal limits. No injuries or pain were noted. The 72-hour neurological assessments were initiated. No further progress notes from that day indicated what/if any new interventions were put in place to prevent another fall. An IDT note, dated 4/5/24, indicated positioning in the chair was assessed and the resident was "checked on" frequently through the night. The call light was within reach. The post fall assessments for Resident C were completed on 4/4/24 at 6:45 p.m., 4/5/24 at 10:44 p.m., 4/6/24 at 2:39 p.m., and 4/6/24 at 5:42 p.m., and then Resident C had another fall. The post fall assessment were not completed as the form indicated which was every shift for three days (72 hours). On 4/6/2024 at 2:33 p.m., a nursing note indicated Resident C had been up in her wheelchair and had tried to stand up from the wheelchair multiple times. At 3:20 p.m., a nursing note indicated Resident C was on fall follow-up with neurological checks and vital signs being completed. The nursing note indicated the following, "Will continue monitoring and report changes per protocol." The note did not indicate what/if any new interventions were put in place to prevent another fall. 2c. On 4/6/2024 at 5:38 p.m., a nursing note indicated Resident C had been sitting in her big chair in her room when she got up, with no shoes on, and was wearing her anti-embolism stockings when she had an unwitnessed fall. Resident C was unable to explain what had occurred. Her range of motion, neurological status, and vitals were assessed. A new 72-hour neurological			

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	assessment was initiated, and the resident was transferred to her wheelchair and taken to the television lounge. A nursing note, dated 4/6/24 at 10:32 p.m., indicated her daughter had visited and placed "footies" on her mom. No further progress notes from that day indicated what/if any new interventions were put in place to prevent another fall. A post fall assessment for Resident C was completed on 4/6/24 at 5:42 p.m. and 4/7/24 at 7:22 a.m., then Resident C had another fall. The post fall assessments were not completed every shift. 2d. A nursing note, dated 4/7/24 at 7:14 a.m., indicated Resident C was found on the floor after walking into her neighbor's room without a walker. Resident C was found to have a knot to the back of head and was complaining of a slight headache. No further progress notes from that day indicated what/if any new interventions were put in place to prevent another fall. 2e. A nursing note, dated 4/8/24 at 2:00 a.m., indicated Resident C was found on the floor of her room naked. She had taken off her incontinent brief and had an incontinent episode on the floor which was beside her. Resident C was confused and speaking incoherently. She was assisted off the floor into her wheelchair and taken to the common area where she could be more closely monitored by staff. The writer of the nursing note indicated they were "instructed to just continue to monitor resident per facility protocol. Will continue to monitor." Later that day, on 4/8/24, Resident C was found to have a urinary tract infection. No further progress notes from that day indicated what/if any new interventions were put in place to prevent another fall.			

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	Post fall assessments for Resident C were completed on 4/8/24 at 2:00 a.m., 4/8/24 at 8:02 p.m., 4/9/24 at midnight, and 4/10/24 at 11:55 p.m. The post fall assessments were not completed every shift. An IDT note, dated 4/8/24, indicated Resident C had an increase in anxiety and behaviors. The note indicated the following, "Frequent checks in place" and the resident was brought to the common area for closer observation. Another IDT note, dated 4/8/24, indicated Resident C had poor safety awareness and was brought to the dining room for the morning meal. 2f. A nursing note, dated 6/30/24 at 10:00 a.m., indicated Resident C was found on the floor in her room. A post fall assessment, dated 6/30/24, indicated Resident C's fall was unwitnessed. She was attempting to toilet herself. Resident C's electronic health record (EHR) nor her physical chart contained the 72-hour neurological assessments for the falls on 4/6/24, 4/7/24, or 4/8/24. An interview conducted with DON, on 7/17/24 at 1:19 p.m., indicated no further neurological assessments were found for Resident C's fall events. Resident C's fall care plan, dated 5/16/23, indicated to ensure the resident was wearing non-skid footwear when ambulating or propelling wheelchair, initiated on 5/16/23, and had not been revised to include new interventions to prevent a future fall. 3. The clinical record for Resident F was reviewed			

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	on 7/10/24 at 2:00 p.m. The diagnosis included, but was not limited to, Alzheimer's disease. An Admission MDS assessment, dated 6/13/24, indicated Resident F was cognitively impaired. A care plan, dated 6/10/24, indicated Resident F had a "potential for falls r/t [related to] deconditioning gait/balance problems, unaware of safety needs. fall in the home, down unknown length of time, seen in ER [emergency room] and admit to hospital. Fall in facility impulsive. no injuries..." During a Confidential Interview, they indicated Resident F had fallen, on 6/10/24, and the staff had not assessed or monitored the resident after her fall. A fall incident report for Resident F, dated 6/10/24, indicated the following, "...Writer found resident sitting on the floor while doing his rounds inside her room beside her bed. Resident's back is leaning on her wheelchair...When writer asked resident why she is sitting on the floor, resident replied 'I am trying to transfer myself to my bed, I slid down from my wheelchair...Resident was assessed for any injury, resident claimed that she did not hurt herself and she is not in any pain. Neuro check was started, vitals was taken, after assessing the resident is free from pain or injury, resident was helped get back to her bed safety by two person using a gait belt..." The medical provider and the resident's Power of Attorney was made aware of the incident. A nursing progress note, dated 6/11/24, indicated the following, "...Writer found resident inside her room sitting on the floor with legs spread apart, she was beside her bed and she is leaning back on			

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	her wheelchair, she said she was trying to transfer her self from chair to bed, she said she slid down from her wheelchair, no injury, no pain noted as of this time, neuro check, skin assessment started, notified [Power of Attorney]...ADON [Assistant Director of Nursing] notified. Resident was transferred back safely to her bed using two person assist with gait belt, placed call light within reach. Endorsed to oncoming nurse." The post fall assessments for Resident F were provided by the DON on 7/15/24 at 9:30 a.m. The assessments indicated the staff were to assess the resident after a fall, every shift, for three days. The following dates and times indicated a post fall assessment was conducted on Resident F: 6/10/24 at 11:13 p.m., 6/11/24 - there were no post fall assessments conducted, 6/12/24 at 10:59 a.m., and 6/13/24 at 2:33 a.m. The resident's clinical record did not include post fall assessments that were conducted on every shift for Resident F's fall that had occurred on 6/10/24. A nursing progress note for Resident F, dated 6/21/24, indicated the following, "...Resident was on the floor in Aspen activity room. She said she got up from her wheel chair and sat on the floor. She denied falling. She was taken back to the room." The resident's clinical record did not include assessments and monitoring of the resident at the time of the fall, on 6/21/24, or post fall assessments, every shift, for 3 days.			

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	A medical provider note for Resident F, dated 6/21/24, indicated the following, "...She had a fall a few days today [sic] and another one today unwitnessed without injury. Per nursing, patient was found in activity room and reported getting up from her wheelchair to sit on the floor...Patient resting in bed, does not recall fall earlier today. She reports no current pain...." A written statement by License Practical Nurse (LPN) 3, dated 7/9/24, indicated the following, "...I was walking to the unit where I was to work on that day and I saw this lady [Resident F] sitting upright on the floor, I asked if she was okay, she said yes, I asked if she fell, she answered no. I saw the aid walking towards her and I asked the aid if he knew who she was, the aid said yes and that he was going to get her to her room and then for breakfast. I walked pass. I reported to the NP [Nurse Practitioner] that day how I met the resident and that I went ahead to check her v.s. [vital signs] when I realized she was in the unit I was assigned to work that day. She denied falling and denied having any pain at the time I asked." An interview was conducted with the DON on 7/15/24 at 2:46 p.m. She indicated, on 6/21/24, Resident F did have a fall. The nurse did not consider the resident had fallen after observing Resident F sitting on the floor in the activity's room. During an interview, LPN 3 had stated to the DON she had arrived on the unit and had observed a resident sitting on the floor in the activity room. She places herself on the floor all the time, so she did not consider it a fall. The DON indicated a fall assessment, incident report, and fall post assessments, every shift, should have been conducted after Resident F had fallen on 6/21/24.			

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	4. The clinical record for Resident M was reviewed on 7/10/24 at 2:30 p.m. The diagnosis included, but was not limited to, stroke. A nursing progress note for Resident M, dated 7/8/24, indicated the following, "...At approximately 7:10 a.m. the [Certified Nursing Assistant] CNA reported witnessed fall. CNA stated she was preparing resident for transfer when he slipped out of bed. Writer went in to assess resident. Res [Resident] lying on floor in supine position. Pillow under head for comfort. Bed sheet appears to be slightly off bed. Res assessed for injuries. No injuries observed at this time. No c/o [complaints of] pain or discomfort at this time. VS [vital signs] obtained...Will continue to monitor resident..." A fall incident report, dated 7/8/24, indicated the following, "CNA called writer into room stating she had to lower resident to floor. Writer walked in resident lying in supine position. Pillow under head. No clutter observed. Sheets slightly off bed...Assess for pain/injuries. vs [vital signs] obtained. Res [Resident] M assisted to w/c [wheelchair] via hoyer lift [mechanical lift]...." An IDT (Interdisciplinary Team) note, dated 7/8/24, indicated the following, "Per charge nurse report CNA was getting resident ready for the morning and ready for transfer. He was sitting on the side of the bed and prior to CNA getting assist with the transfer resident slid from the bed. Resident not to sit on side of bed without 2 person assist." A post fall evaluation for Resident M, dated 7/9/24, was in the clinical record, but there was nothing documented under the fall evaluation.			

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	The clinical record did not include post fall assessments every shift for three days after the fall event on 7/8/24. An interview was conducted with Resident M on 7/17/24 at 9:42 a.m. He indicated he was sitting on the edge of the bed reaching for the handles of the stand-up lift (mechanical lift) and slid from the bed to the floor. He landed on his buttocks. He does not recall hurting himself. An interview conducted with the DON, on 7/15/24 at 2:46 p.m., indicated fall assessments, incident reports, and post fall assessments should be conducted every shift after fall events. 5. The clinical record for Resident D was reviewed on 7/10/24 at 2:20 p.m. The diagnoses included, but were not limited to, left sided hemiplegia (paralysis of left side) and dependence on wheelchair. A care plan, dated 5/9/24, indicated Resident D had a potential for falls related to a history of traumatic brain injury, immobility, non-ambulatory, and abnormal posture due to hemiplegia affecting his left dominant side. He was non-compliant with transferring self and refused the Hoyer lift. The goal was for him to be free of falls. The interventions included, but were not limited to, ensure non-skid footwear when ambulating or propelling wheelchair, initiated 5/9/24, reacher at bedside, initiated 5/15/24, and reacher at bedside and personal items in reach, revised 6/17/24. A Health Status Note, dated 5/12/24, indicated that Resident D had been found sitting on the floor. Resident D indicated he was reaching for a pair of pants on the back of his chair and slid out of his wheelchair. Resident D had denied pain and discomfort at the time. The physician and family			

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	were notified. An Admission MDS assessment, dated 5/14/24, indicated Resident D was cognitively intact and used a wheelchair for mobility. He had a history of falls in the 6 months prior to admission and had experienced 1 fall without injury since his admission to the facility. A Fall Note, dated 6/16/24 at 11:50 a.m., indicated Resident D was found on the floor with a laceration to the back of the scalp. Resident D indicated he was trying to fix his shoe when he fell, although both of the resident's shoes appeared to be on his feet appropriately. The physician and the family had been notified and Resident D had been sent to an acute care hospital due to his head laceration. A Health Status Note, dated 6/19/24 at 9:38 p.m., indicated Resident D was found on the floor lying on his back in front of his bed. Resident D indicated that he was trying to turn off his light when he fell. The physician was notified, and the facility had attempted to notify the family. An Incident Note, dated 7/12/24 at 3:05 p.m., indicated Resident D was transferring to the toilet with a CNA (Certified Nursing Assistant) and slipped off. The clinical record did not contain IDT (Interdisciplinary Team) notes regarding the review to the fall events for 6/16/24, 6/19/24, and 7/12/24. During an interview, on 7/15/24 at 10:32 a.m., the TM (Therapy Manager) indicated that falls were discussed in the morning meetings.			

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	During an interview, on 7/16/24 at 10:09 a.m., the DON indicated that the IDT notes about falls were not in the clinical record. The incident reports/ fall risk assessments were internal documents and not part of the clinical record. The IDT notes were on the incident reports. An incident report should be filled out after each fall occurrence. The IDT team informed staff of new interventions and added the interventions to the assignment sheet. On 7/16/24 at 10:21 a.m., the DON provided the incident reports for Resident D's falls. There was not an incident report completed for the fall that happened on 6/19/24. During an interview, on 7/16/24 at 10:53 a.m., Resident D indicated he did not have a reacher in his room. He used to have a reacher but could not find it. He would use one if he had it. Resident D had fallen in the bathroom on 7/12/24. He did not use the toilet riser that was present in his bathroom because it was too small for him. He would like to have a bar on the right side of his toilet so that he could pull himself up from the wheelchair when he needed to use the toilet. On 7/16/24 at 12:44 p.m., Resident D's room was observed with the DON. The DON indicated she did not see a reacher in his room and would get him a new reacher. During an interview, on 7/16/24 at 12:52 p.m., the DON indicated that post fall assessments should be conducted each shift for three days following a fall. On 7/15/24 at 9:30 a.m., the DON provided the current Fall Risk and Post Fall Assessment Policy which indicated the following, "... Purpose: To identify treatable conditions and improve the			

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	overall quality of life for the resident. T o conduct appropriate assessments prior to and after falls. To intervene when possible to "break" a fall. To detect reversible causes of falls and to identify supportive aids/ interventions to prevent falls. Policy: A Fall Risk and other appropriate Assessments will be completed at the time of admission, reviewed/ updated quarterly. When residents continue to have falls, the inter-disciplinary team, including the physician, will conduct additional evaluations to identify any additional measures to reduce or prevent further occurrences...Procedure... 4. Conduct Physical and Mental Status Assessment...h. Assess any other areas not previously Evaluated, including completely checking skin and scalp Check to assess for bruises, abrasions, etc... under clothing. i. Document assessment findings in nursing notes and make necessary notifications. j. Complete Incidents Report...." On 7/15/24 at 12:54 p.m., the DON provided the current Fall Prevention and Management Policy which indicated the following, "...It is the policy of [facility] to assess and identify potential fall risk for each resident to implement person centered interventions with the goal of preventing falls and fall related injuries. Definition: Unintentional change in position coming to rest on the ground, floor or onto the next lower			

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	surface... The fall may or may not be witnessed, reported by the resident or an observation or identified when a resident is found on the floor or ground... Procedure...b. The Interdisciplinary Team [IDT] will: i. initiate fall prevention review. The review will include and is not limited to, the medical record review and review of environment. ii. The resident-centered care plan will be initiated with fall preventions and reviewed with the IDT at morning meeting and with each fall. iii. Complete education of staff, IDT members, and update CNA assignment sheets regarding interventions and actions implemented to decrease the risk of the resident experiencing a fall and fall related injury...3. Fall Occurrence: a. Resident will not have significant movement or a transfer until the licensed nurse assesses for injuries and gives direction to move and or transfer the resident. If a significant injury is present which will be impacted by movement such as a possible hip fracture, the resident will be made comfortable and will not be moved. Physician and emergency transport services will be contacted immediately. b. The licensed nurse will: i. Assess the Resident for injuries... And provide first aid as needed. ii. Notify the appropriate individuals as directed on the incident accident report form...iii. Obtain vital sign...iv. Fully			

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	Complete the Resident Incident in the electronic medial[sic] record. This will include new intervention[s] initiated following the fall. v. Complete a Fall Risk Assessment. vi. Review and revise resident care plan and point of care to ensure interventions[s] are in place to reduce the risk of future occurrences. These interventions should be based on the findings of the initial review and assessment...." This citation relates to Complaints IN00437923 and IN00431844. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident who was on continuous oxygen therapy had a physician's order for the oxygen in the electronic health record (EHR) and was provided the necessary care and services by not changing the humidification container as per policy for 1 of 2 residents reviewed for respiratory care. (Resident C) Findings include:	F 0695	This tag was cited due to an order for oxygen not being present in the medical record for one resident using oxygen, and a humidifier bottle not being changed timely. Corrections for Resident C and any other residents that may be impacted by this will be addressed as follows: An in-service will be provided to	09/08/2024

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	An observation of Resident C's oxygen humidification container was conducted on 7/11/24 at 10:03 a.m. The humidification container was dated, 6/1/24, and the water that was left in the container was cloudy. During the observation, Resident C was wearing her nasal cannula and was receiving humidified oxygen from that container however the water in the humidifier container was not bubbling. A review of Resident C's clinical record conducted, on 7/16/24 at 1:49 p.m., indicated Resident C's diagnoses included, but was not limited to, congestive heart failure, dementia, chronic bronchitis, and anxiety disorder. A review of Resident C's hospice binder was conducted on 7/17/24 at 3:09 p.m. The hospice binder contained written orders, from 4/12/24, which included an order for continuous oxygen at 2 liters via a nasal cannula. The most recent care plan for Resident C did not include a care plan for the use of continuous oxygen nor was the continuous oxygen noted on the Significant Change Minimum Data Set (MDS) assessment completed on 4/19/24. An interview with Licensed Practical Nurse (LPN) 9, on 7/17/24 at 3:09 p.m., indicated Resident C was on hospice and when a resident was on hospice services, they usually would place an order for continuous oxygen. She indicated, when hospice places an order for a resident, they will handwrite the order for the facility's nursing staff to place into the electronic health record. It is the responsibility of the facility staff to ensure all hospice orders are placed into the computer system. LPN 9 verified that Resident C's		nursing staff regarding the facility's procedures for having medical records complete with all orders (regardless of whether hospice or other providers are participating), as well as procedures for changing oxygen tubing and humidifier bottles **(Attachment N)** To monitor compliance with these policies, audits will be conducted for all residents using oxygen to be sure orders are present and that both tubing and humidifier bottles are changed weekly. Audits will be conducted weekly over the next month, and monthly until the facility has 100% compliance over 90 days. **(Attachment O)** All corrections for this tag will be completed by September 8, 2024.	

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	continuous oxygen order was not in their EHR system, but the order was listed on the admission orders from the hospice provider. LPN 9 indicated the oxygen tubing and humidification bottle were to be changed weekly. An interview conducted with Assistant Director of Nursing (ADON), on 7/17/24 at 3:25 p.m., indicated Resident C's care plan should contain a plan of care regarding the use of continuous oxygen and the care services needed. The ADON indicated the care services with the use of oxygen are to be completed by the facility's staff and not the hospice company. An Oxygen Administration policy was provided by Director of Nursing (DON) on 7/17/24 at 3:59 p.m. The policy indicated; the purpose of the procedure was to provide guidelines for safe oxygen administration. "Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident...General Guidelines...b. The nasal cannula is a tube that is placed approximately one-half into the resident's nose...Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure...3. Humidifier bottle...Steps in the Procedure...12. Be sure these is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through." 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management.			

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	The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to administer a pain-relieving patch as ordered for 1 of 4 residents reviewed for pain. (Resident K) Findings include: 1. The clinical record for Resident K was reviewed on 7/10/24 at 11:00 a.m. The diagnosis included, but was not limited to, low back pain. A care plan for pain, dated 7/11/24, indicated Resident K was to receive medications as ordered. A physician order, initiated on 7/5/24 and implemented on 7/9/24, indicated the resident was to receive an Aspercreme lidocaine patch for her lower back. The patch was to be applied for 12 hours and removed after 12 hours. The Treatment Administration Record (TAR), dated July 2024, indicated the lidocaine patch was to be applied at 8:00 a.m., and removed at 8:00 p.m. The TAR was documented by the staff the patch was applied, as ordered, from 7/9/24 through 7/17/24. The staff documented the removal of the lidocaine patch, as ordered, from 7/9/24 through 7/16/24. An interview was conducted with Resident K and Resident K's Representative on 7/10/24 at 11:58 a.m. Resident K indicated she does not receive the pain patch as ordered for her lower back at times.	F 0697	This tag was cited due to a resident's pain patch being missed on one date and administered late on another. To correct this for Resident K and any other residents receiving trans-dermal patches the facility will do the following: 1 Educate all Nurses that medications are to be administered timely and as ordered. **(Attachment P)** 2 Conduct audits of any medications administered via trans-dermal patches to be sure they are dated, and that the dates on them reflect timely changes. **(Attachment Q)** 3 Audit residents who receive transdermal pain control via interview regarding satisfaction with pain control. **(Attachment Q)** Audits will be conducted weekly for a month, and monthly thereafter until the facility has 100% compliance over 90 days.	09/08/2024

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	At the time of the interview, she did not have a pain patch on her lower back. An observation and interview was conducted of Resident K on 7/17/24 at 2:30 p.m. The resident indicated she had not received a pain patch that day. She still had the patch in place that was applied 7/16/24. She was supposed to receive the patch in the morning, and then it was to be removed in 12 hours. Resident K's lower back was observed with a lidocaine patch dated 7/16/24. An interview was conducted with Registered Nurse (RN) 6 on 7/17/24 at 2:51 p.m. She indicated she had not had time to apply the scheduled 8:00 a.m., lidocaine patch for Resident K that day. She indicated she would apply the patch after the interview. After the interview with RN 6, an observation was made of RN 6 removing a lidocaine patch, dated 7/16/24, and applied a new lidocaine patch. This citation relates to Complaint IN00437923. 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure pre and post assessments were conducted to a resident receiving dialysis for 1 of 1 resident reviewed for dialysis. (Resident 176)	F 0698	This tag was cited due to one resident not having pre and post assessments on 2 dialysis days. Resident 176 continues to receive	09/08/2024

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	Findings include: The clinical record for Resident 176 was reviewed on 7/10/24 at 3:00 p.m. The diagnosis included, but was not limited to, chronic kidney disease. The resident's admission date was 7/5/24. A care plan for Resident 176, dated 7/8/24, indicated the resident "needs hemodialysis r/t [related to] renal failure." A physician order, dated 7/10/24, indicated Resident 176 was to receive dialysis every Monday, Wednesday, and Friday. The residents clinical record did not include pre or post assessments on the following dialysis days: 7/12/24 - Friday, and 7/15/24 - Monday An interview was conducted with the Director of Nursing on 7/18/24 at 9:19 a.m. She indicated staff should be conducting pre and post assessments with Resident 176 on dialysis days. A dialysis policy was provided by the Assistant Director of Nursing on 7/18/24 at 10:36 a.m. The policy indicated the following, "...Policy: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of resident's receiving dialysis..." 3.1-37(a)		dialysis and will have pre and post assessments completed for every dialysis appointment. Nurses will receive in-service education to remind them of the need to complete assessments prior to and after dialysis appointments. Additionally, the facility has added a new requirement to add pre/post assessment orders to the MAR/TAR to remind nurses to complete this assessment. **(Attachment R)** The facility will assure that these assessments are not missed for residents who receive dialysis services by auditing all dialysis charts weekly to determine whether the pre and post assessments are being completed. This will be an on-going audit, as we have very few residents on dialysis. **(Attachment S)** All corrections for this tag will be completed by September 8, 2024.	
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications stored in the facility's medication carts were not expired for 1 of 6 medication carts observed within the facility. (Facility) Findings include: A review of the facility's medication storage rooms and medication carts was conducted on 7/17/24 at 10:05 a.m. The following was observed:	F 0761	This tag was cited due to a recently expired insulin being used. Resident P has had no undesirable effect from using the insulin on 7/17. And the expired medication has been destroyed. All nurses will receive in-service education regarding the need to date each vial of insulin or other injectable medications when	09/08/2024

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	On the Willow hallway with LPN (Licensed Practical Nurse) 3, on 7/17/24 10:10 a.m., the medication cart contained a multi-dose vial of Humalog insulin with an open date, of 6/13/24, for Resident P without an expiration date on vial or prescription medication bottle that housed vial of insulin. An interview conducted with LPN 3, on 7/17/24 at 10:12 a.m., she indicated all opened insulin vials should have an open date and expiration date. The open insulin vials expire after 28 days from opening. The clinical record for Resident P was reviewed on 7/17/24 at 1:32 p.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus. A physician order, dated 2/19/24, indicated Resident P was on a sliding scale of Humalog injection solution 100 UNIT/ml (milliliters) (insulin lispro). The sliding scale was the following: 151 - 200 blood sugar readings = 2 units of insulin, 201 - 250 blood sugar readings = 4 units of insulin, 251 - 300 blood sugar readings = 6 units of insulin, 301 - 350 blood sugar readings = 8 units of insulin, 351 - 400 blood sugar readings = 10 units of insulin If greater than 450, repeat in 20 minutes and report the second reading if >450, subcutaneously before meals for diabetes mellitus. The Medication Administration Record (MAR), dated July 2024, for Resident P was reviewed on 7/17/24 at 1:40 p.m. The MAR indicated that insulin was administration by LPN 3 on 7/17/24 at 7:00 a.m. LPN 3 administered 2 units of Humalog to Resident P for a blood sugar of 160.		opened and mark them for the expiration date. In order to prevent recurrence for this resident or any other resident, the facility will inspect all medication carts for expired medications weekly for one month and monthly thereafter. Monthly inspections will be conducted by our Pharmacy provider as well on an on-going basis. **(Attachment T)** All corrections for this tag will be completed by September 8, 2024.	

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	An interview was conducted with LPN 3 on 7/17/24 at 11:10 a.m. She indicated she did not give the 7:00 a.m. dose of insulin from the expired vial of Humalog but from another source and looked in the medication cart and in the medication room for several minutes but was unable to provide the vial in which the insulin was given from. A guideline for Medication Labeling and Storage policy, received on 7/17/24 at 1:32 p.m., from the ADON (Assistant Director of Nursing) indicated the following, "Medication and biologicals are stored in the packaging, containers or other dispensing systems in which they are received...Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days ...If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items." 3.1-25(o)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 0804	This tag was cited due to 2	09/08/2024

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	Based on interview and record review, the facility failed to provide residents with a palatable grilled cheese sandwich for 2 of 5 residents reviewed for food. (Residents 62 and 93) Findings include: The clinical record for Resident 62 was reviewed on 7/18/24 at 10:40 a.m. An Annual Minimum Data Set (MDS) assessment, dated 7/3/24, indicated Resident 62 was cognitively intact. The clinical record for Resident 93 was reviewed on 7/18/24 at 10:45 a.m. A Quarterly MDS, dated 5/7/24, indicated Resident 93 was cognitively intact. An interview conducted with Resident 62, on 7/11/24 at 11:08 a.m., indicated she recently had ordered a grilled cheese sandwich from the "always available" menu and when she received the sandwich, she described it as "two pieces of toast with a cold slice of cheese in the middle". Resident 62 indicated the sandwich was not appetizing since the cheese was not even melted on the sandwich nor had it been grilled at all. An interview conducted with Resident 93, on 7/18/24 at 12:05 p.m., indicated, about a week ago, she had ordered a grilled cheese sandwich from the "always available" menu and what she received was two pieces of toast with a slice of cheese that was microwaved so the cheese would melt. When asked why she believed they had placed the sandwich in a microwave, Resident 93 indicated it was because "it was hard like a hockey puck". A review of the Dining Committee Meeting notes, from 6/4/24, indicated they discussed what is		residents' complaints regarding the quality of their grilled cheese sandwiches. Westminster Village has engaged a new contracted Dining Service in order to upgrade the dining program and food quality. This service will provide high standards for food service delivery including cooking methods, recipes, and quality monitoring, but will provide a tableside, restaurant-style dining experience for our residents. The new provider offers an extensive training program to assure the competency of staff. The dining program offers a means to provide anonymous feedback through a kiosk called "Happy or Not" which allows residents to input, via touchscreen, details regarding their meal experience. Feedback from these kiosks is monitored at least monthly, but as frequently as weekly by dining service management. **(Attachments U & V)** Additionally, we will review food service satisfaction during our monthly Resident Council meetings and use the feedback from residents to make ongoing improvements. Notes from these meetings will be our audit. Additionally, health center management will order food from this venue at random dates and	

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	always available on the menus and talked about feedback regarding food. An interview conducted with the Director of Dietary Service, on 7/18/24 at 1:12 p.m., indicated they have had two food council meetings, and the last one was at the beginning of June. He indicated, previously, the procedure to make a grilled cheese sandwich was to utilize the toaster and not to grill the sandwich. He indicated with the new dietary company's changes, now the grilled cheese sandwiches will be made by utilizing a pan or grill and will no longer use the toaster to make the sandwiches. 3.1-21(a)(1) 3.1-21(a)(2)		mealtimes in order to sample food quality and document their feedback in the “Happy of Not” kiosk with their contact information so the audit is documented and reviewed. All Corrections for this tag will be completed by September 8, 2024.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure a clean, sanitized, and well maintained kitchen by staff who failed to wear beard restraints to prevent hair from contacting food, ensure proper storage of food products by keeping track of when to discard perishable foods stored in the refrigerator, maintain a minimum washing temperature in 1 of 2 dishwashers in the facility, and failed to sanitize rolling kitchen carts before placing them in the storage room in kitchen 1 of 2 where food products are stored with the potential to affect 97 of 123 residents who receive food from the kitchen. (Facility) Findings include: 1. An observation of the facility kitchens 1 and 2 was conducted, on 7/10/24 at 10:20 a.m., with the Kitchen Manager (KM 2) and the Dining Service Director (DSD). An observation was conducted of kitchen 1, on 7/10/24 at 10:20 a.m., of the walk-in refrigerator. There was an open box containing individual Jello cups with the expiration date, of 6/29/24, and an open box of exposed hot dogs with the expiration date of 6/27/24. A Production, Purchasing, Storage Policy was received, on 7/16/24 at 12:10 p.m., from the Assistant Director of Nursing (ADON). The policy indicated the following, ""Foods past the "use by", "sell by", "best by", or "enjoy by" date should be discarded ...Cover, label and date unused portions and open packages ...All food	F 0812	Our new dining service has implemented new sanitation practices that will improve sanitation standards throughout the kitchen. Specifically, expiration dates will be more easily monitored by using a bright orange tag on all food products which will keep expiration dates and opened dates highly visible. The dishwasher was immediately taken out of service and will be repaired to reach temperatures at or above 150 degrees. Another, appropriately functioning dishwasher, is being used until repairs are made. Staff will be provided in-service education regarding the cleaning of carts, monitoring of dishwasher temperatures, inspection of cleaned dishes, wearing of hair/beard restraints, and the system for monitoring for the expiration of foods. The Registered Dietician or Food Service Director will conduct weekly sanitation audits over the next month, and then monthly thereafter in order to monitor these corrections. **(Attachment W)** These audits are performed using an online application via a tablet or cellphone and allow for real-time	09/08/2024

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	shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption."" 2. An observation was conducted of kitchen 2, on 7/10/24 at 10:55 a.m., with KM 2 and DSD. It was observed that the dishwasher wash cycle temperature reached 147 degrees Fahrenheit (F). An interview was conducted with DSD, and he indicated that the machine needed to be at least 150 degrees and he would put in a work order. A second attempt to reach the proper temperature was made, on 7/11/24 at 9:25 a.m., after the maintenance man had been in to service the dishwasher and the dishwasher temperature reached 148 degrees F. Cook 2 placed an out of order sign on the dishwasher and the manufacturer was called. During an interview, on 7/15/24 at 12:44 p.m., Resident 22 indicated her silverware was dirty when she unwrapped it from the cloth napkin. An observation was conducted on 7/15/24 at 1:40 p.m. The dietary staff brought in two test trays with five plates, three of which were dirty with food debris. A Hobart manufacturers instruction manual for the dishwasher located in kitchen 2 was provided, on 7/16/24 at 12:10 p.m., by ADON. The manual indicated the following, "Operating temperatures for all models are as follows: Hot Water minimum wash temperature is 150 degrees F, and the recommended wash temperature is 150 degrees F." 3. A tour of kitchen 1 was conducted, on 7/10/24 at 10:20 a.m., with KM 2 and DSD. Three soiled rolling carts were observed in the food storage		review of data and trends. All corrections for this tag will be completed by September 8, 2024.	

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	area. An interview conducted, on 7/10/24 at 10:25 a.m., with KM 2 indicated that the carts should be cleansed prior to being placed in the storage area. An observation conducted of kitchen 1, on 7/12/24 at 9:57 a.m., noted 5 soiled rolling carts found in the storage area. A Diversey Food Carts cleansing guide was provided, on 7/16/24 at 12:10 p.m., by ADON. The guide indicated recommended products, frequency, time required and procedures for cleaning the rolling carts. A Sanitation and Infection Prevention / Control for the Cleaning of Food and Nonfood Contact Surfaces policy was provided, on 7/16/24 at 12:10 p.m., by ADON. The policy indicated the following, "To prevent cross-contamination, kitchenware and food-contact surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of the operations during which time contamination may have occurred." 4. An observation and interview were conducted, on 7/12/24 at 9:57 a.m., in kitchen 1. Cook 2 and Kitchen Aid 2 (KA 2) were observed standing in the food preparation area without beard coverings. Both Cook 2 and KA 2 had facial hair and beards exceeding ¼ of an inch in length. An interview conducted, on 7/12/24 at 9:59 a.m., with Cook 2 indicated he was unaware beard covers were needed. An observation and interview were conducted of kitchen 2 on 7/12/24 at 10:34 a.m. Chef 2 indicated he was unaware beard covers were needed and he would check with the new supply company to get beard covers that are appropriate.			

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	An Associate Conduct Personal Appearance and Handwashing policy received, on 7/16/24 at 12:10 p.m., from the ADON indicated the following, "For Associates working in food service restrain all facial hair with a beard net/restraint." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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	its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during medication administration by picking up dropped pills with bare hands and not cleaning a blood pressure device in-between resident use for 2 of 3 medication administration observations. (Residents 275, 176, 173, 72, and K) Findings include: 1. A medication administration observation was conducted on, 7/11/24 at 8:20 a.m., with Qualified Medication Aide (QMA) 2. QMA 2 was in the process of removing medication cards to prepare morning medications for Resident 275. QMA 2 prepared metoprolol (blood pressure medication) and pressed down on the medication card for Senna (medication used to treat constipation) to where a pill of Senna was dropped on the medication cart. QMA 2 picked up the pill with her bare hands and placed the Senna pill into the medication cup. QMA 2 proceeded to prepare glycopyrrolate (medication for secretions) 2 milligrams by pressing the medication card and one pill fell onto the medication cart. QMA 2 proceeded to pick up the pill with her bare hands and placed it into the medication cup. QMA 2 opened a drawer to the medication cart to remove a bottle containing pyridostigmine (medication used to treat muscle weakness/muscle disease), shook the bottle to place a pill in the medication lid, and then took the pill with her bare hands to place into the medication cup. QMA 2 proceeded to administer all prepared medications to Resident 275.	F 0880	QMA 2 has been provided additional instruction regarding infection control practices during medication administration and will receive 3 follow-up observations to monitor competency to demonstrate the effectiveness of instruction. RN3 received instruction to use only facility-provided blood pressure cuffs. All nurses will receive in-service instruction regarding the disinfection requirements for our blood pressure cuffs. **(Attachment X)** The facility will audit competency of Nurses and QMA's regarding infection control during medication administration and vitals monitoring through observations to be conducted with various nurses and QMA's with at least 4 observations being conducted with 4 different staff each month. These observations will be conducted monthly for 6 months as a quality assessment measure. **(Attachment Y)** All corrections for this tag will be completed by September 8, 2024.	09/08/2024

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	2. A medication administration observation was conducted on, 7/12/24 from 8:50 a.m. to 9:05 a.m., with Registered Nurse (RN) 3. RN 3 utilized a wrist blood pressure device to obtain the blood pressure for Resident 176. RN 3 then proceeded to prepare morning medications for Resident 173. Before administering medications to Resident 173, RN 3 obtained blood pressure with the same wrist blood pressure device. Resident 72 approached RN 3 and requested their blood pressure be checked in the hallway. RN 3 proceeded to utilize the same wrist blood pressure device on Resident 72. RN 3 then prepared morning medications for Resident K. Prior to administering the morning medications for Resident K, RN 3 obtained blood pressure utilizing the same wrist blood pressure device. The wrist blood pressure device was not cleaned and/or disinfected before or after being utilized on Residents 176, 173, 72, and K. An interview conducted with RN 3, on 7/12/24 at 9:00 a.m., indicated the wrist blood pressure device was her own. She had the device for "so many years" and was unsure if there were instructions on how often to clean and what to clean it with. RN 3 indicated she usually cleans the wrist blood pressure device between every other resident. A policy titled "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES", revised 01/17, was provided by the Administrator on 7/15/24 at 9:48 a.m. The policy indicated the following, "...ORAL MEDICATION ADMINISTRATION...Procedures...C. For solid medications...1) Pour or push the correct number of tablets or capsules into the souffle cup, taking care to avoid touching the tablet or capsule, unless wearing gloves...."			

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	3.1-18(b)(1) 3.1-18(l)			
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an effective pest control program so that it remained free of flying insects in a food storage area within 1 of 2 kitchens potentially affecting 97 out of 123 residents. (Facility) Findings include: A tour of kitchen 1 was conducted, on 7/10/24 10:20 a.m., with Kitchen Manager (KM 2) and Dining Service Director (DSD). Tiny flying insects, resembling gnats, were observed flying around in the air and on products in storage area. There were several seen and observation reflected a count of 9 seen in immediate area. An interview was conducted with KM 2 on 7/10/24 at 10:33 a.m. She indicated that there should not be any flying insects in the kitchen or storage area. 3.1-19(f)(4)	F 0925	The facility's kitchens have a formalized pest control program as outlined in **(Attachment Z)** All kitchen staff will be educated regarding this program and their responsibilities as they relate to this program. The program is in place and the kitchen is free of pests at this time. During sanitation audits the Registered Dietician or Food Service Manager will include inspections to determine the effectiveness of the pest control program. These audits will be conducted weekly for the first month and monthly thereafter as part of our ongoing monitoring of sanitation standards in our kitchens. **(Attachment W)** All corrections for this tag will be completed by September 8, 2024.	09/08/2024
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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 10, 11, 12, 15, 16, 17, and 18, 2024 Facility number: 000084 Residential Census: 72 Westminster Village North was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on July 24, 2024.	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Westminster Village North Health Center provides anything other than a high quality of care to its residents. Westminster considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction:	